MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Blurred or decreased vision

Structured history, interpretation & clinical review

Symptom 43 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Loss or reduction of vision is separated by pain, tempo, one/both eyes, field pattern, retina/vascular clues, optic-nerve features, and neurological associations.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Blurred or decreased vision

1A. Immediate safety screen

Is there sudden visual loss, a curtain or missing field, or a new large shower of floaters or flashes?

☐ No ☐ Yes ☐ Not sure

If Yes: Contact an emergency eye service or emergency department now.

Is there a painful red eye, halos, vomiting, marked light sensitivity, or pain with eye movement?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek same-day emergency eye assessment; sudden visual loss requires emergency care now.

Is there new double vision with weakness, severe headache, confusion, imbalance, or difficulty speaking?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record onset or last-known-well time.

Is there eye protrusion, fever, eyelid swelling, new inability to move the eye, or recent eye trauma?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye/orbital assessment now.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which eyes and field are affected?

☐ All or central vision in one eye ☐ Both eyes diffusely ☐ A missing side or specific field area ☐ Peripheral vision or bumping into objects

Is there eye pain, redness, or pain with eye movement?

☐ Pain with eye movement ☐ Painful red eye ☐ Painless ☐ Not sure

How did it develop?

☐ Seconds to minutes ☐ Hours to days ☐ Weeks, months, or longer ☐ Transient/recurrent episodes

Are there flashes, many new floaters, a curtain, halos, or distorted straight lines?

☐ Curtain or field defect ☐ Distortion or central blur ☐ Halos around lights ☐ None

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Sudden painless monocular visual loss

Which eyes and field are affected? All or central vision in one eye
Is there eye pain, redness, or pain with eye movement? Painless
How did it develop? Seconds to minutes

Emergency warning pattern — Now

Sudden painless monocular loss is an emergency retinal/optic-nerve vascular pathway.

Differential to review:

- Retinal artery/vein occlusion, retinal detachment, or vitreoretinal disorder
- Optic neuritis, ischemic optic neuropathy, or compressive optic-nerve disease

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Painful visual-loss pathway

Is there eye pain, redness, or pain with eye movement? Pain with eye movement / Painful red eye

Emergency warning pattern — Now

Pain with visual loss requires emergency ocular or optic-nerve assessment.

Differential to review:

- Optic neuritis, ischemic optic neuropathy, or compressive optic-nerve disease
- Angle closure, uveitis, corneal, or other painful ocular process

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 3: Acute visual-field or cerebral pattern

Which eyes and field are affected? A missing side or specific field area / Peripheral vision or bumping into objects
How did it develop? Seconds to minutes / Hours to days

Emergency warning pattern — Now

Acute field loss may be retinal or cerebral and requires urgent in-person localization.

Differential to review:

- Retinal artery/vein occlusion, retinal detachment, or vitreoretinal disorder
- Cerebral visual-pathway lesion, migraine, or refractive/media cause

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 4: Progressive visual decline

How did it develop? Weeks, months, or longer

Prompt clinical review pattern — Promptly

Progressive loss requires ophthalmic examination and selected optic-nerve or visual-pathway evaluation.

Differential to review:

- Optic neuritis, ischemic optic neuropathy, or compressive optic-nerve disease
- Cerebral visual-pathway lesion, migraine, or refractive/media cause

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 5: Retinal warning phenomena

Are there flashes, many new floaters, a curtain, halos, or distorted straight lines? Curtain or field defect / Distortion or central blur

Urgent assessment pattern — Same day

A curtain or new distortion needs prompt retinal assessment; an acute curtain is an emergency.

Differential to review:

- Retinal artery/vein occlusion, retinal detachment, or vitreoretinal disorder

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Unresolved-information pathway: New visual loss needs prompt in-person assessment.

Urgent assessment pattern — Same day

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Retinal artery/vein occlusion, retinal detachment, or vitreoretinal disorder

Discriminating features: Sudden painless monocular loss, curtain/field defect, flashes/floaters, or distortion.

Logical investigations: Immediate ophthalmic assessment and dilated retinal examination; vascular evaluation for retinal arterial ischemia.

3.2 Optic neuritis, ischemic optic neuropathy, or compressive optic-nerve disease

Discriminating features: Pain with eye movements or painless nerve-type loss; color vision, RAPD, age and vascular context discriminate.

Logical investigations: Urgent ophthalmic/neuro-ophthalmic examination, visual fields and OCT; MRI and vascular/inflammatory tests as indicated.

3.3 Angle closure, uveitis, corneal, or other painful ocular process

Discriminating features: Painful red eye, halos, vomiting, photophobia, or ocular inflammation.

Logical investigations: Emergency eye examination including pressure, slit-lamp and fundus assessment.

3.4 Cerebral visual-pathway lesion, migraine, or refractive/media cause

Discriminating features: Homonymous field loss or neurological signs suggest brain; transient positive phenomena suggest migraine; gradual bilateral blur may be ocular/refractive.

Logical investigations: Confrontation/formal fields, ocular and neurological examination; urgent brain imaging for acute homonymous or associated deficits.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127

2. American Academy of Ophthalmology. (2020). *Preferred Practice Pattern: Comprehensive Adult Medical Eye Evaluation*. https://www.aao.org/preferred-practice-pattern/comprehensive-adult-medical-eye-evaluation-ppp